STATE OF CALIFORNIA
DEPARTMENT OF CORRECTIONS AND REHABILITATION
OPOS 07C (7/06)

OFFICE OF PEACE OFFICER SELECTION

PEACE OFFICER VISION VERIFICATION

FOR SURGERY, UNCORRECTED VISION EXCEEDS 20/60, OR CONTACT LENSES WEARER

Candidate's Name: ______________________________
PRINT *Last* *First* *MI*

Address: ______________________________ **SSN:** ______________
Street

______________________________ **Telephone Number:** ( ) ______________
City *State* *ZIP*

CLASSIFICATION: **(Circle One)** **CO** **MTA** **YCC** **YCO** **CSW**

AUTHORIZATION TO RELEASE INFORMATION

To determine my eligibility for employment as a Peace Officer with the California Department of Corrections and Rehabilitation (CDCR), I authorize you to release to CDCR any and all medical information and/or records concerning my vision. This authorization is valid until the selection process is completed.

Candidate's Signature: ______________________________ **Date:** ______________

TO OPTOMETRIST/OPHTHALMOLOGIST:

Your patient has applied for a Peace Officer position with CDCR and we need verification that his/her vision meets our corrected vision requirements. We also require disclosure of the means of correction. Please evaluate your patient's visual acuity and indicate both corrected and uncorrected levels of acuity in the designated area below. The information provided will normally be used by non-medical staff; therefore, in addition to listing the acuity measurements, all questions must be answered.

1. Has the patient had refractive eye surgery (i.e., RK, PRK, Lasik, etc.) within the last 12 months? Yes ❑ No ❑
   If "Yes", indicate date of last surgery: ______________________________
2. Is the patient's visual acuity 20/20 or better in each eye uncorrected? Yes ❑ No ❑
3. If the patient's visual acuity is not 20/20 or better in each eye uncorrected, is his/her visual acuity corrected to 20/20 in each eye? Yes ❑ No ❑
4. What method of correction does your patient currently use? Check one: Glasses ❑ Hard/Semi Rigid contact lenses ❑ Soft contact lenses ❑
   If contact lenses are used, has your patient been a successful contact lenses wearer for the last 12 months? Yes ❑ No ❑
5. If "No", indicate the date the patient began using contact lenses: ______________________________
6. Document the patient's uncorrected visual acuity?
   Right eye: ______________ Left eye: ______________ Both eyes: ______________
7. In the section below, please complete the prescription information for the correction Item 3.

Glasses					
Rx		Sphere	Cylinder	Axis	Prism
DIST	OD				
	OS				
ADD	OD	+	Bifocal Type		
	OS	+	Trifocal Type		

Contact Lenses			
Rx	Power	Base Curve	Diameter
OD			
OS			

Doctor's Original Signature	Date
Doctor's Printed Name	Telephone Number
Doctor's Address	City, State ZIP

Doctor, please mail the completed form no later than ______________________________ to:

DEPARTMENT OF CORRECTIONS AND REHABILITATION
PRE-EMPLOYMENT MEDICAL UNIT
2201 BROADWAY
SACRAMENTO, CA 95818-2572